

reduction for any co-payments, coinsurance, and deductibles required by the Medicare program from the patient.

(f) *Exceptions to payment calculation.* Notwithstanding paragraph (e) of this section, if an amount has been negotiated with the hospital or its agent by the I/T/U, the I/T/U will pay the lesser of: The amount determined under paragraph (e) of this section or the amount negotiated with the hospital or its agent, including but not limited to capitated contracts or contracts per Federal law requirements;

(g) *Coordination of benefits and limitation on recovery.* If an I/T/U has authorized payment for items and services provided to an individual who is eligible for benefits under Medicare, Medicaid, or another third party payor—

(1) The I/T/U shall be the payor of last resort under § 136.61;

(2) If there are any third party payers, the I/T/U will pay the amount for which the patient is being held responsible after the provider of services has coordinated benefits and all other alternative resources have been considered and paid, including applicable co-payments, deductibles, and coinsurance that are owed by the patient; and

(3) The maximum payment by the I/T/U will be only that portion of the payment amount determined under this section not covered by any other payor; and

(4) The I/T/U payment will not exceed the rate calculated in accordance with paragraph (e) of this section or the contracted amount (plus applicable cost sharing), whichever is less; and

(5) When payment is made by Medicaid it is considered payment in full and there will be no additional payment made by the I/T/U to the amount paid by Medicaid (except for applicable cost sharing).

(h) *Claims processing.* For a hospital to be eligible for payment under this section, the hospital or its agent must submit the claim for authorized services—

(1) On a UB92 paper claim form (until abolished, or on an officially adopted successor form) or the HIPAA 837 electronic claims format ANSI X12N, version 4010A1 (until abolished, or on an officially adopted successor form)

and include the hospital's Medicare provider number/National Provider Identifier; and

(2) To the I/T/U, agent, or fiscal intermediary identified by the I/T/U in the agreement between the I/T/U and the hospital or in the authorization for services provided by the I/T/U; and

(3) Within a time period equivalent to the timely filing period for Medicare claims under 42 CFR 424.44 and provisions of the Medicare Claims Processing Manual applicable to the type of item or service provided.

(i) *Authorized services.* Payment shall be made only for those items and services authorized by an I/T/U consistent with part 136 of this title or section 503(a) of the Indian Health Care Improvement Act (IHCIA), Public Law 94-437, as amended, 25 U.S.C. 1653(a).

(j) *No additional charges.* A payment made in accordance with this section shall constitute payment in full and the hospital or its agent may not impose any additional charge—

(1) On the individual for I/T/U authorized items and services; or

(2) For information requested by the I/T/U or its agent or fiscal intermediary for the purposes of payment determinations or quality assurance.

§ 136.31 Authorization by urban Indian organization.

An urban Indian organization may authorize for purchase items and services for an eligible urban Indian (as those terms are defined in 25 U.S.C. 1603(f) and (h)) according to section 503 of the IHCIA and applicable regulations. Services and items furnished by Medicare-participating inpatient hospitals shall be subject to the payment methodology set forth in § 136.30.

§ 136.32 Disallowance.

(a) If it is determined that a hospital has submitted inaccurate information for payment, such as admission, discharge or billing data, an I/T/U may as appropriate—

(1) Deny payment (in whole or in part) with respect to any such services, and;

(2) Disallow costs previously paid, including any payments made under any methodology authorized under this subpart. The recovery of payments